EXHIBIT A

Patient Information

Patient Name	MRN	Sex	DOB
Roman A[redacted]	103334179	Male	[redacted]

Operative Report signed by John J Vaccaro, MD at 4/25/2018 15:03

Author: John J Vaccaro, MD	Service: (none)	Author Type: Physician
Filed: 4/25/2018 15:03	Date of Service: 4/23/2018 0:00	Status: Signed
Editor: John J Vaccaro, MD (Physician)		Trans ID: H1593044

Dictation Time:	Trans Time:	Trans Doc Type:	Trans Status: Available
4/24/2018 21:42	4/25/2018 7:57	Operative Report	

SURGEON: John J. Vaccaro, MD
DATE: 04/23/2018

OPERATION: Left Upper Extremity: Neuroplasty with nerve wrapping.

ANESTHESIA: General
4X loupe magnification
NerveProtector D = 5 mm.; L = 40 mm.; Lot: LB969304

PRE-OP DX: Complex open fracture of the left upper extremity with associated ulnar nerve injury and multiple trauma.

POST-OP DX: Left Upper Extremity: Complex fracture of the left olecranon with disruption of the ulnar nerve.

HISTORY: This patient is a 31-year-old male who was not initially evaluated by me. He was immediately taken to the Hackensack University Medical Center, to the operating room for an acute open communuted fracture of the left upper extremity. The
patient's record reveals that he is 31 years old, was riding a Vespa on a highway and hit a large pothole that caused him to crash. The patient had a loss of consciousness, but was wearing a helmet at the time and he was immediately evaluated by the trauma service. Evaluation by the trauma service revealed a complex olecranon fracture that was open; as well as a nondisplaced proximal humeral fracture. A consultation was called with orthopedics, Dr. Keller.

PHYSICAL EXAMINATION: Initial exam revealed a well-developed, well-nourished male who was awake and alert. Head, ears, eyes, nose, neck, and oral cavity: The neck C-spine was nontender, and was cleared for surgery. He had a laceration involving the anterior mental area and lacerations involving the frenulum of the upper lip (these were not addressed by me). Examination of the chest, heart, lungs and abdomen have been carried out in great detail by Trauma. Chest, heart, lungs, and abdomen had been carried out by the trauma service. Examination
of the patient's left upper extremity revealed that he had a large stellate laceration with

exposed bone and muscle. All during this time, I was not made aware to evaluate the motor function
or sensory function of his hand, wrist and forearm. He was immediately taken to the operating room where Dr. Julie Keller addressed the olecranon fracture and noted there was a disruption of the ulnar nerve and a hand consultation was requested and I responded in the operating room with the patient under general anesthesia.
After exploring the wound and pulse irrigation of the wound, the ulnar nerve was noted to be frayed, but not completely transected. It was
frayed in such a way with approximately an 8 mm area of fraying, but there was no gap. With this in mind and after again pulse irrigating the area there was soft tissue swelling. It was elected to place a nerve wrapping over the frayed area. With the placement of the
nerve protector, this was done carefully and meticulously not to go and violate the unaffected proximal and distal ends of the ulnar nerve. This was placed and held in place with 5-0 nylon. Once this was completed, Dr. Keller returned to the operative site and addressed the musculature and the soft tissue closure.

CC: John J. Vaccaro, MD

Electronically signed by John J Vaccaro, MD at 4/25/2018 15:03

Revision History

Media

Electronic signature on 4/23/2018 18:59
Electronic signature on 4/23/2018 18:59

Activity Date

Activity Date
Apr 23, 2018

Routing History

EXHIBIT B

JOHN J. VACCARO, M.D., P.A., F.A.C.S.

Diplomate American Board of Plastic Surgery
Fellow of the American College of Surgeons

Member
American Society for Aesthetic Plastic Surgery, Inc.

Member
AMERICAN SOCIETY OF PLASTIC SURGEONS

ASSIGNMENT OF BENEFITS
&
LTD. POWER OF ATTORNEY

I irrevocably assign to you, my medical provider, all of my rights and benefits under my insurance contract and/or any employee welfare benefit plan for payment for services rendered to me, including but not limited to all of my rights under "ERISA" applicable to the medical services at issue. I authorize you to file insurance claims on my behalf for services rendered to me and this specifically includes filing arbitration/litigation in your name on my behalf against the PIP carrier/health care carrier. I irrevocably authorize you to retain an attorney of your choice on my behalf for collection of your bills. I direct that all reimbursable medical payments go directly to you, my medical provider. I authorize and consent to your acting on my behalf in this regard and in regard to my general health insurance coverage and I specifically authorize you to pursue any administrative appeals conducted pursuant to "ERISA".

In the event the insurance carrier responsible for making medical payments in this matter does not accept my assignment, or my assignment is challenged or deemed invalid, I execute this **limited/special power of attorney** and appoint and authorize your collection attorney as my agent and attorney to collect payment for your medical services directly against the carrier in this case, in my name, including filing arbitration demand or lawsuit. I specifically authorize that attorney to file directly against that carrier in my name or in your name as a medical provider rendering services to me and designate your collection attorney as my attorney in fact. I further grant limited power of attorney to you as my medical provider to receive and collect directly from the insurance carrier money due you for services rendered to me in this matter, and hereby instruct the insurance carrier to pay you directly any monies due you for medical services you rendered me. **I authorize you and or your attorney to receive from my insurer, immediately upon verbal request, all information regarding last payment made by said insurer on my claim, including date of payment and balance of benefits remaining.**

I authorize you and or your attorney to obtain medical information regarding my physical condition from any other health care provider, including hospitals, diagnostic centers, etc., and I specifically authorize such health care provider(s) to release all such information to you about me, including medical reports, X-ray reports, and any other report or information regarding my physical condition.

Dated: 04/30/2018

Patient's Signature

EXHIBIT C

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

Oxford Health
P O Box 29130
Hot Springs AR 71903

CARRIER

PICA ☐ ☐ ☐ PICA ☐ ☐ ☐

1. MEDICARE ☐ (Medicare#)	MEDICAID ☐ (Medicaid#)	TRICARE ☐ (ID#/DoD#)	CHAMPVA ☐ (Member ID#)	GROUP HEALTH PLAN ☐ (ID#)	FECA BLK LUNG ☐ (ID#)	OTHER ☒ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1347513901

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Al[redacted]y, Roman	[redacted] M ☒ F ☐	Al[redacted], Roman
5. PATIENT'S ADDRESS (No., Street) [redacted]	6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street) [redacted]
CITY [redacted] / STATE NY	8. RESERVED FOR NUCC USE	CITY [redacted] / STATE NY
ZIP CODE [redacted] / TELEPHONE (Include Area Code) [redacted]		ZIP CODE [redacted] / TELEPHONE (Include Area Code) [redacted]
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER: MS33861
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☐ YES ☒ NO	a. INSURED'S DATE OF BIRTH MM DD YY: 04 26 86 / SEX M ☒ F ☐
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ☐ YES ☒ NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☒ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME: Oxford Health
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☒ NO *If yes,* complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED Signature On File DATE 06 11 19

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED Signature On File

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY / QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM / TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 04 23 18 TO 04 25 18
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? ☐ YES ☒ NO / $ CHARGES 0 00
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0		22. RESUBMISSION CODE / ORIGINAL REF. NO.
A. S44 02XA B. C. D. / E. F. G. H. / I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 04 23 18 04 23 18	21		64718	A	14225 00	1		NPI	1861463267
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
22 2550670 ☐ ☒	2814	☐ YES ☒ NO	$ 14225 00	$ 6000 00	8225 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (732 914 2100)
John J Vaccaro M D SIGNED 06 11 19 DATE	Hackensack University Medical Center 30 Prospect Avenue Hackensack NJ 07601 1914 a. 1609862036 b.	John J Vaccaro M D P A 202 Route 37 West Suite 1 Toms River NJ 08755 8055 a. 1730372665 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

EXHIBIT D

Oxford Health Plans NY Inc
UnitedHealthcare - Oxford
4 Research Drive
Shelton CT 06484
Phone: 1-800-666-1353

STD - PRA

UnitedHealthcare Oxford

PROVIDER REMITTANCE ADVICE

CHECK DATE: 10/22/18
TIN: 222550670
VENDOR NAME: JOHN J VACCARO MD PA
CHECK NUMBER: 16522853
CHECK AMOUNT: $6,000.00
VENDOR ID: DO4937-P933245

JOHN J VACCARO MD PA
PO BOX 249
HASBROUCK HEIGHTS NJ 07604

PATIENT: ROMAN A[redacted]

MEMBER ID: 13475139*01 PATIENT ACCT NUM: 2814 CLAIM NUMBER: 8122E28099.02
PROVIDER ID: P933245 PROVIDER NAME: VACCARO, JOHN

DATE(S) OF SERVICE	DESCRIPTION OF SERVICE	QTY	BILLED AMT	MAXIMUM AMOUNT	DEDUCTIBLE AMT	COPAY/COINS AMT	COB AMT	WITHHOLD AMT	PAYMENT AMT	PATIENT RESP AMT	ADJ CODE
04/23/18	REVISE ULNAR NERVE AT ELBOW (64718)	1	$14,225.00	$6,000.00			$0.00	$0.00	$6,000.00	$0.00	A31P
CLAIM 8122E28099.02 SUBTOTAL			$14,225.00	$6,000.00			$0.00	$0.00	$6,000.00	$0.00	
								TOTAL PAYABLE TO PROVIDER	$6,000.00		

Adjustment Code Description

A31P The maximum amount allowed for this primary procedure has not been reduced based on the multiple procedures policy.

For the above claims please visit www.oxhp.com

EXHIBIT E

HACKENSACK UNIVERSITY MEDICAL CENTER
TRANSCRIBED REPORT

MEDICAL RECORD #: 100086095
BILLING #: 2002435778
PATIENT NAME: A[redacted], ANAUM
AGE: 2
ADMIT DATE: 01/15/2017
DISCHARGE DATE: 01/15/2017
UNIT: ROOM: PE3401
SVC: PER
PT STS: E

Operative Report signed by John J Vaccaro, MD at 1/17/2017 14:39

Author: John J Vaccaro, MD	Service: (none)	Author Type: Physician
Filed: 1/17/2017 14:39	Date of Service: 1/15/2017 18:41	Note Type: Operative Report
Status: Signed	Editor: John J Vaccaro, MD (Physician)	
Trans ID: H529582	Trans Status: Available	Dictation Time: 1/16/2017 18:05
Trans Time: 1/16/2017 23:25	Trans Doc Type: Operative Report	

ASSISTANT:
ANESTHESIOLOGIST:
DATE: 01/15/2017
OPERATION:
1. Frontal Area: Exploration and debridement of jagged vertically-based avulsion-disruption of the frontal area. There was repair and reconstruction of the frontalis muscle. There was plastic surgical repair and reconstruction of the dermis and its integument with adjacent tissue (2.5 cm).
2. Left Infraorbital Area: Exploration and debridement of second-degree abrasion of the left infraorbital area (3 cm) with topical dressing (no benefits of suturing).

ANESTHESIA:
1% lidocaine with 1:100,000 dilution of epinephrine block
4X loupe magnification
The patient was monitored.

PRE-OP DX: Facial trauma.

POST-OP DX:
1. Frontal area: Full-thickness jagged vertically-based oval avulsion-type disruption of the frontal area (2 cm). There was complete disruption of the dermis and its integument. There was complete disruption of the underlying frontalis muscle.
2. Left infraorbital area: Second-degree abrasion of the left infraorbital area, (3 cm) (no benefit of suturing).

HISTORY: This patient is a 2-1/2-year-old Middle Eastern female who presents to us in the accompaniment of her mother and father. History is obtained that the patient fell on the outside sidewalk area, resulting in a full-thickness jagged avulsion-disruption of the frontal area, as well as a deep second-degree abrasion of the left infraorbital area. There was no history of any known loss of consciousness, no nauseousness, no vomiting, no change in mental

status, no history of any seizures prior to or after the injury. Upon evaluation on presentation, the patient's mother and father requested and agreed to a plastic surgical consultation for the involved injury and plastic surgical treatment for the involved injury. They were fully aware of the options and they were fully aware of the residual effects from the involved injury, and the need for follow-up care and the ongoing healing process to evaluate the final outcome of the surgery.

Past Medical History: The patient has no history of known medical allergies. No history of medical problems and the patient is up-to-date in immunizations.

Physical Examination: Reveals a well-developed, well-nourished female, alert, oriented, acting appropriate for the trauma involved and appearing neurologically intact. Examination of the head, ears, eyes, nose, neck and oral cavity: Head is normocephalic. Examination of the frontal area reveals a vertically based jagged oval full-thickness avulsion-disruption of the soft tissue. Supraorbital rims reveal no evidence of any crepitus or tenderness. The globes of the eyes are asymptomatic for complaints. Pupils reactive. Extraocular movements within normal limits. The infraorbital area on palpation reveals no evidence of any infraorbital step-off, no infraorbital anesthesia, and the malar eminences are bilaterally symmetrical on palpation. Examination of the left infraorbital area does reveal a second-degree abrasion, but no benefits of suturing. The nasal pyramid externally reveals no evidence of any soft tissue injuries, no crepitus of the nasal bones and intranasal examination reveals no evidence of any heme and the septum is intact. The ears are within normal limits. Temporomandibular joints reveal no evidence of any trismus and no evidence of any subluxations. No change in bite and the zygomatic arches are nontender. Maxilla is stable. Maxillary and mandibular teeth are intact. No evidence of any palatine hematoma. Examination of the neck is supple. Chest, heart, lungs and abdomen grossly within normal limits. Neurologically, II-XII of the patient are grossly within normal limits. The extremities are grossly within normal limits.

After evaluating the patient, it was discussed with the patient's mother and father at length the nature of the injury; that she will be left with a residual effects from the involved injury, the quality of which would have to be evaluated with time. Possibilities of bleeding, infection, hematoma, possibilities of further surgeries in the future; the options involved, as well as the need for follow-up care and the ongoing healing process to evaluate the final outcome of the surgery. They were aware that the surgical procedure would be carried out utilizing a block anesthesia. The patient's mother and father were fully aware of the procedure, the risks, the options, the need for follow-up care. The consent was fully informed consent. They insisted we Proceed. The procedure took place as follows.

PROCEDURE: The patient was premedicated, brought into the operating area, placed on the operating table in the supine position with the head elevated and vital signs noted and monitored to be stable. The entire face and neck area were washed of all dried blood and the wounds re-evaluated and inspected.

CC: John Vaccaro, M.D.

A time-out was called. The operative sites, as well as the patient identified and all agreed upon.

The patient's face and neck area was sterilely cleaned, prepped and draped in the usual fashion and isolated in a sterile towel field. There was induction of block anesthesia utilizing 1% lidocaine with 1:100,000 dilution of epinephrine block of the frontal area and the left infraorbital area as a topical anesthetic. Allowing a 7-10 minute period of time to elapse for both hemostasis and anesthetic effect, the procedure was able to proceed. The left infraorbital area was debrided of devitalized tissue and foreign bodies within the abrasion, but there was no benefits from any suturing.

My attention then turned to the frontal area. The wound was irrigated with saline solution and explored for foreign bodies and the wound was then debrided of all dead and devitalized tissue with the micro iris scissors. The wound edges were revised as necessary with a #15 scalpel blade, followed by the micro iris scissors. The wound was irrigated. The skin edges undermined with the #15 scalpel blade, followed by the micro iris scissors. Hemostasis was obtained with the cautery and the wound copiously irrigated with saline solution.

Reconstruction was begun by identifying and isolating the underlying frontalis muscle, returning it to its normal anatomical position, repairing with interrupted sutures of 6-0 Vicryl evenly spaced along the length of the muscle. The wound was irrigated with saline solution and layered closure of the overlying soft tissue performed with multiple interrupted sutures of 6-0 Vicryl in lower dermis and integumental layer, coapting the edges in an edge-to-edge manner. The wound was again irrigated with saline solution. Plastic repair of the upper dermis was performed with multiple interrupted sutures of 6-0 Vicryl with buried knots, coapting the edges in an edge-to-edge manner. The area was irrigated and meticulous plastic repair of the upper dermis and epidermal layer took place, first by placing interrupted sutures of 6-0 Prolene coapting the edges in an edge-to-edge manner, followed by a running suture of 6-0 Prolene. The area was irrigated and checked for hemostasis. The wound was then dressed with Xeroform gauze, bacitracin ointment, Steri-Strips and a contoured dressing, including the left infraorbital area.

The patient tolerated the entire procedure well; but immediately postoperatively had an episode of vomiting, which the primary physician was made aware of. The patient was to be discharged on a short course of antibiotics, analgesics for pain, no aspirin or aspirin products.

Instructions to the parents to keep the dressings dry, clean and intact. If the dressings come off or gets wet, clean the areas with bacitracin ointment, no crusting or scabbing and a protective dressing. This included the left infraorbital area and the frontal area. The benefits of a tennis sweatband were discussed. Neurological head sheet instructions were to be given, and a light diet for today. Call with any problems. Call for an office appointment to be seen within the week. Ice packs off and on for first 48 hours and no showers to the area. Try to limit activities.

The patient's parents were fully aware of the procedure, the risks, the options, the need for followup care. After an adequate period of time and

CC: John Vaccaro, M.D.

observation, the patient was able to be discharged in the accompaniment of her parents for follow-up in our office.

CC: John Vaccaro, M.D.[JV1.1]

Revision History

	User Key	Date/Time	User	Provider Type	Action
>	JV1.1	1/17/2017 14:39	John J Vaccaro, MD	Physician	Sign
	[N/A]	1/17/2017 10:43	John J Vaccaro, MD	Physician	Edit
	[N/A]	1/16/2017 23:25	John J Vaccaro, MD	Physician	Edit

EXHIBIT F

JOHN J. VACCARO, M.D., P.A. F.A.C.S.

Member
American Society for Aesthetic Plastic Surgery, Inc.

Diplomate American Board of Plastic Surgery
Fellow of the American College of Surgeons

Member
AMERICAN SOCIETY OF PLASTIC SURGEONS

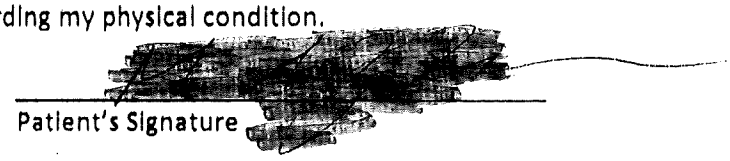
ASSIGNMENT OF BENEFITS
&
LTD. POWER OF ATTORNEY

I irrevocably assign to you, my medical provider, all of my rights and benefits under my insurance contract and/or any employee welfare benefit plan for payment for services rendered to me, including but not limited to all of my rights under "ERISA" applicable to the medical services at issue. I authorize you to file insurance claims on my behalf for services rendered to me and this specifically includes filing arbitration/litigation in your name on my behalf against the PIP carrier/health care carrier. I irrevocably authorize you to retain an attorney of your choice on my behalf for collection of your bills. I direct that all reimbursable medical payments go directly to you, my medical provider. I authorize and consent to your acting on my behalf in this regard and in regard to my general health insurance coverage and I specifically authorize you to pursue any administrative appeals conducted pursuant to "ERISA".

In the event the insurance carrier responsible for making medical payments in this matter does not accept my assignment, or my assignment is challenged or deemed invalid, I execute this **limited/special power of attorney** and appoint and authorize your collection attorney as my agent and attorney to collect payment for your medical services directly against the carrier in this case, in my name, including filing arbitration demand or lawsuit. I specifically authorize that attorney to file directly against that carrier in my name or in your name as a medical provider rendering services to me and designate your collection attorney as my attorney in fact. I further grant limited power of attorney to you as my medical provider to receive and collect directly from the insurance carrier money due you for services rendered to me in this matter, and hereby instruct the insurance carrier to pay you directly any monies due you for medical services you rendered me. **I authorize you and or your attorney to receive from my insurer, immediately upon verbal request, all information regarding last payment made by said insurer on my claim, including date of payment and balance of benefits remaining.**

I authorize you and or your attorney to obtain medical information regarding my physical condition from any other health care provider, including hospitals, diagnostic centers, etc., and I specifically authorize such health care provider(s) to release all such information to you about me, including medical reports, X-ray reports, and any other report or information regarding my physical condition.

Dated: 1-23-17



Patient's Signature

EXHIBIT G

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

United Healthcare
P O Box 740800
Atlanta GA 30374

CARRIER

PICA | PICA

1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)
						X

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 925801432

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
A[redacted], Anaum	[redacted] M F X	A[redacted] Mohammad

5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
[redacted]	Self Spouse Child X Other	[redacted]

CITY	STATE	8. RESERVED FOR NUCC USE	CITY	STATE
[redacted]	NJ		[redacted]	NJ

ZIP CODE	TELEPHONE (Include Area Code)	ZIP CODE	TELEPHONE (Include Area Code)
[redacted]	[redacted]	[redacted]	[redacted]

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
		8W9834
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES X NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX: [redacted] M X F
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES X NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES X NO	c. INSURANCE PLAN NAME OR PROGRAM NAME: United Healthcare
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED Signature On File DATE 06 11 19

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED Signature On File

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES X NO $ CHARGES 0 00
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0		22. RESUBMISSION CODE ORIGINAL REF. NO.
A. S01 82XA B. S01 422A C. D. E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 15 17 01 15 17	23		13131		A	6464 00	1		NPI	1861463267
2 01 15 17 01 15 17	23		99284	25	A B	500 00	1		NPI	1861463267
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
22 2550670 X	2578	YES X NO	$ 6964 00	$ 0 00	6964 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (732 914 2100
John J Vaccaro M D 06 11 19 SIGNED DATE	Hackensack University Medical Center 30 Prospect Avenue Hackensack NJ 07601 1914 a. 1609862036 b.	John J Vaccaro M D P A 202 Route 37 West Suite 1 Toms River NJ 08755 8055 a. 1730372665 b.

EXHIBIT H

8B-9531*01*000002-PM-17151-110*C04FICTTOPS

UnitedHealthcare Insurance Company
GREENSBORO SMALL GROUP
PO BOX 740800
ATLANTA GA 30374-0800
PHONE: 1-877-842-3210

STD - PRA

UnitedHealthcare

PROVIDER REMITTANCE ADVICE

DATE: 05/31/17
TIN: 222550670
NPI: 1730372665
PAYEE NAME: JOHN J VACCARO MD PA
TRACE NUMBER: QK 74749483
PAYMENT: $0.00
GROUP NUMBER: 8W9834
GROUP NAME: FW-BCYU1S00 ADP TOTALSOURCE

JOHN J VACCARO MD PA
JOHN J VACCARO MD
PO BOX 249
HASBROUCK HEIGH NJ 07604

PATIENT: ANAUM A[redacted] (CH)

SUBSCRIBER ID:	A 925801432	**SUBSCRIBER NAME:**	MOHAMMAD A[redacted]	**CLAIM NUMBER:**	3297782721 0277204573
CLAIM DATE:	01/15/17-01/15/17	**DATE RECEIVED:**	04/10/17	**PRODUCT:**	CHOYC+
REND PROV ID:	1861463267	**REND PROV:**	J. J VACCARO MD		

PATIENT CONTROL NUMBER	PATIENT ID	AUTH/REF NUMBER	DRG	DRG WEIGHT	CLAIM CHARGE AMOUNT	CLM ADJ AMT	GRP CD	CLM ADJ RSN CD	CLAIM PAYMENT AMOUNT	PATIENT RESPONSIBILITY
2578					$6,964.00				$0.00	$6,964.00

SERVICE LINE DETAIL(S)

LINE CTRL#	DATES OF SERVICE	SUB PROD/ SVC/ MOD	ADJ PROD/ SVC	MOD	REV	UNITS	ADJ QTY	CHARGE	AMOUNT ALLOWED	ADJ AMOUNT	GRP CD	CLM ADJ RSN CD	PAYMENT AMOUNT	REMARK/ NOTES
16104	01/15/17 - 01/15/17		13131			1		$6,464.00	$738.89	$738.89	PR	1	$0.00	CO
										$5,725.11	PR	45		
16105	01/15/17 - 01/15/17		99284	25		1		$500.00	$363.62	$363.62	PR	1	$0.00	CO
										$136.38	PR	45		
CLAIM# 3297782721 0277204573							SUBTOTAL	$6,964.00	$1,102.51	$6,964.00			$0.00	

PAYMENT OF BENEFITS HAS BEEN MADE IN ACCORDANCE WITH THE TERMS OF THE MANAGED CARE SYSTEM.

TOTAL PAYABLE TO PROVIDER	$0.00	

NOTES

PR1 PATIENT RESPONSIBILITY - DEDUCTIBLE AMOUNT

PR45 PATIENT RESPONSIBILITY - CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT.

CO AN OUT-OF-NETWORK PROVIDER OR FACILITY PROVIDED THESE SERVICES. THE CLAIM WAS PROCESSED USING YOUR NETWORK BENEFITS. YOU MAY BE RESPONSIBLE FOR PAYING THE DIFFERENCE BETWEEN WHAT THE FACILITY OR PROVIDER BILLED AND WHAT WAS PAID. THE NOT COVERED AMOUNT MAY NOT APPLY TO YOUR ANNUAL OUT-OF-POCKET MAXIMUM.

THE MEMBER, PROVIDER, OR AN AUTHORIZED REPRESENTATIVE MAY REQUEST RECONSIDERATION OR APPEAL THE DECISION BY SUBMITTING COMMENTS, DOCUMENTS OR OTHER INFORMATION TO UNITEDHEALTHCARE. NETWORK PROVIDERS SHOULD REFER TO THE ADMINISTRATIVE GUIDE FOR CLAIM RECONSIDERATION OR APPEAL INFORMATION. IF YOU ARE A NETWORK PROVIDER APPEALING A CLINICAL OR COVERAGE DETERMINATION ON BEHALF OF A MEMBER, OR A NON-NETWORK PROVIDER APPEALING A DECISION ON BEHALF OF A MEMBER, FOLLOW THE PROCESS FOR APPEALS IN THE MEMBER'S BENEFIT PLAN DOCUMENT. DECISIONS ON APPEALS MADE ON BEHALF OF MEMBERS WILL BE COMPLETED IN 30 DAYS OF SUBMISSION OR WITHIN THE TIMEFRAME REQUIRED BY LAW.

UNITEDHEALTHCARE IS IMPROVING SERVICE TO YOU BY ADOPTING ELECTRONIC PAYMENTS & STATEMENTS (EPS) AS A STANDARD WAY TO PAY CLAIMS. EPS WILL DRAMATICALLY REDUCE THE TIME AND EFFORT YOUR ORGANIZATION SPENDS ON ADMINISTERING PAPER CHECKS AND EXPLANATION OF BENEFITS. GET A HEAD START AND ENROLL TODAY BY SELECTING THE ELECTRONIC PAYMENTS & STATEMENTS LINK FOUND ON THE HOME PAGE WWW.UNITEDHEALTHCAREONLINE.COM OR CONTACT US AT 1-866-UHC-FAST (1-866-842-3278), OPTION 5. FOR MORE INFORMATION ABOUT OUR FREE

EXHIBIT I

Patient Information

Patient Name	MRN	Sex	DOB
Sophie [redacted] B[redacted]	6899017	Female	1/25/2002

Operative Report signed by John J Vaccaro, MD at 1/1/2018 14:54

Author: John J Vaccaro, MD | Service: (none) | Author Type: Physician
Filed: 1/1/2018 14:54 | Date of Service: 12/30/2017 0:00 | Status: Signed
Editor: John J Vaccaro, MD (Physician) | Trans ID: H1580012

Dictation Time:	Trans Time:	Trans Doc Type:	Trans Status: Available
12/31/2017 19:43	1/1/2018 3:36	Operative Report	

SURGEON: John J. Vaccaro, M.D.
CO-SURGEON: N/A
ASSISTANT: N/A
ANESTHESIOLOGIST:
DATE: 12/30/2017

OPERATION: Facial Trauma
1) Upper Lip: Exploration and debridement of avulsion loss of the substance of the right upper lip (approximately 20%), extending through the white aspect; through the vermilion border; through the red aspect's mucocutaneous roll; and extending through the oral vestibule. There was repair and reconstruction of the orbicularis oris muscle of the white aspect. There was repair and reconstruction of the dermis and integument of the white aspect with adjacent tissue (3 cm). There was repair and reconstruction of the red aspect's mucocutaneous roll, with inclusion of the vermilion border, utilizing a right laterally based mucocutaneous flap (4 x 3 cm).
Intraorally, there was repair and reconstruction of the avulsion defect with loss of substance of the vestibular mucosa, utilizing a vestibuloplasty of the orbicularis oris muscle and overlying vestibular mucosa.
2) Nose: Puncture wounds of the right alar of the nose (no benefits of suturing).
3) Right Hand: Puncture wounds of the volar metacarpal area of the hand (no benefits of suturing).

ANESTHESIA:
1% lidocaine with 1:100,000 dilution of epinephrine block
4X loupe magnification
intravenous antibiotics administered and completed preoperatively
The patient was monitored.

PRE-OP DX: Complex facial soft tissue trauma.

POST-OP DX: Facial Trauma:
1) Upper Lip: Complex avulsion of the right upper lip with loss of substance (3 x 2 x 2 cm), extending through the white aspect, through the vermilion border, through the red aspect's mucocutaneous roll, and extending

through the oral vestibule. There was avulsion loss of the dermis and integument of the white aspect and avulsion loss of the underlying orbicularis oris muscle of the white aspect. There was avulsion of the architecture of the vermilion border. There was avulsion of the dermis and integument of the red aspect's mucocutaneous roll and the underlying orbicularis oris muscle's red aspect's mucocutaneous roll.

Intraorally, there was avulsion of the vestibular mucosa, with avulsion and loss of the underlying vestibular mucosa and the orbicularis oris muscle.

2) Nose: Puncture wounds of the right alar of the nose (no benefits of suturing).

3) Right Hand: Puncture wounds of the volar metacarpal area of the hand (no benefits of suturing).

HISTORY: This patient is a 15-year-old female, who presents to us in the accompaniment of her mother and father. The history is obtained from the patient that she was savagely attacked by an animal within the confines of an old friend's home, resulting in loss of substance of the right upper lip and injuries to the nose and right hand. There was no history of any head trauma and no history of any eye trauma. The patient did
incur puncture wounds of the volar surface of the right hand and puncture wounds of the nose. Upon evaluation and presentation, the patient's mother and father requested and agreed to a plastic surgical consultation for the involved injury and plastic surgical treatment for the involved injury. They were fully aware of the options. They were fully aware of the residual effect from the involved injury, the need for followup care, and the ongoing healing process to evaluate the final outcome of the surgery.

PAST MEDICAL HISTORY: The patient has no history of known medical allergies, no history of medical problems, and the patient is up-to-date in immunizations. Last menstrual period was 3 weeks previously. The patient's parents and the patient deny pregnancy, and she denies the use of birth control pills or birth control device.

PHYSICAL EXAMINATION: General: She is a well-developed, well-nourished female, alert, oriented, acting appropriately for the trauma involved and appearing neurologically intact. Head, Ears, Eyes, Nose, Neck, and Oral Cavity: Examination of the head is normocephalic. Examination of the ears is within normal limits. Temporomandibular joints reveal no evidence of any trismus and no evidence of any subluxation. There is no change in bite, and the zygomatic arches are nontender. Examination of the supraorbital rims reveal no evidence of any soft tissue injuries. The globes to the eyes are asymptomatic
for complaints. The pupils are reactive. Extraocular movements are within normal limits.
Examination of the upper lip reveals a large soft tissue defect with loss of substance, extending through the white aspect, the vermilion border, the red aspect's mucocutaneous roll, and extending in an oblique direction through the oral vestibule, with loss of substance. Examination of the nasal pyramid externally reveals puncture wounds of the right lateral alar. On palpation, there is no evidence of any crepitance, and intranasal examination reveals no

evidence of any heme, and the septum is intact. The maxilla is stable. Maxillary and mandibular teeth are intact. There is extension of the loss of soft tissue through the oral vestibule. No evidence of any palatine hematoma. Examination of the neck is supple. Chest, Heart, Lungs, and Abdomen: Grossly within normal limits. Neurological: II-XII, the patient is grossly within normal limits. Extremities: Examination of the patient's right hand reveals puncture wounds on the volar surface of the right hand at the distal metacarpal area. There was full flexion and extension without pain and the neurovascular bundles were intact. There is no benefit of any suturing in this area
other than as discussed that topical treatment would be performed.
After evaluating the patient, it was discussed with the patient's mother and father at length the nature of the injuries, the fact that she would be left with residual effects from the involved injuries, the quality of which would have to be evaluated with time. The possibilities of bleeding, infection, hematoma, possibilities of further surgeries in the future, the options involved, as well as the need for followup care and the ongoing healing process to evaluate the final outcome of the surgery. They were aware that the surgical procedure would be taking place utilizing a block anesthesia. We answered all of the patient's mother's and father's questions concerning the surgical procedure. The consent was a fully informed consent. They insisted that we proceed, and the procedure took place as follows.

DESCRIPTION OF PROCEDURE: Intravenous was started. Intravenous antibiotics were administered and completed. The patient was brought into the operating area and placed on the operating room table with the head elevated and vital signs noted and monitored to be stable. The mouth and face were washed of all dried blood and heme. The vermilion border in what normally would be its position was carefully outlined with a tattooing marking pencil, and the proposed musculocutaneous flap reconstruction of the red aspect was carefully outlined from its lateral component as well as the oral vestibule. Vital signs were noted and monitored to be stable. A time-out was called. The operative site as well as the patient were identified and all agreed upon. The patient's face was sterilely cleaned, prepped and draped in the usual fashion, and isolated in a sterile towel field. There was a maxillary block anesthesia utilizing 1% lidocaine with 1:100,000 dilution of epinephrine block. Allowing a 7-10 minute period of time to elapse for both hemostasis as well as the anesthetic effect, the wound was copiously irrigated with saline solution and explored. Careful exploration of the wound failed to reveal any evidence of any foreign bodies. The wound was then debrided of all dead and devitalized tissue with the micro iris scissors. The wound edges of the white aspect were revised as necessary with a #15 scalpel blade, followed by the micro iris scissors. The wound was irrigated, and the skin edges of the white aspect were undermined with the #15 scalpel blade, followed by the micro iris scissors. Meticulous hemostasis was obtained with the cautery. The wound was copiously irrigated with saline solution.
Reconstruction of the white aspect was then begun by identifying and isolating the underlying orbicularis

oris muscle of the white aspect. The musculature layer was then advanced and repaired with
interrupted mattress sutures of 6-0 Vicryl. The wound was again irrigated with saline solution. A layered closure of the overlying soft tissue aspect of the white aspect was performed with interrupted sutures of 6-0 Vicryl in the lower dermis and integumental layer, coapting the edges on an edge-to-edge manner. The upper dermis was then repaired with interrupted sutures of 6-0 Vicryl with buried knots, coapting the edges on an edge-to-edge manner. The plastic repair of the upper dermis and epidermal layer of the white aspect was repaired with interrupted sutures of 7-0 nylon, evenly spaced along the length of the wound, and then 7-0 nylon in a running fashion, meticulously coapting the edges on an edge-to-edge manner. Upon completion of this then, the area of the white aspect was then irrigated.
My attention then turned to the red aspect's mucocutaneous roll, the soft tissue defect and loss, as well as the vermilion border. Utilizing a micro iris scissors, the orbicularis oris muscle and the overlying dermis and integument were then undermined and then released from the commissure of the right upper lip. With the release of the muscle and development of the musculocutaneous flap, the musculature layer was then repaired and coapted with the medial component with interrupted sutures of 6-0 Vicryl. The lower dermis and integumental layer of the red aspect were repaired with interrupted sutures of 6-0
Vicryl with buried knots. The upper dermis and epidermal layer of the red aspect's mucocutaneous roll was then repaired first with interrupted sutures of 6-0 nylon, coapting the edges on an edge-to-edge manner and also restoring the Vermillion border. The area was irrigated and checked for hemostasis.
My attention then turned towards the intraoral component. Here, the defect of the vestibular mucosa muscle was undermined and released from tethering at the level of the sulcus. This was then advanced and repaired as a layered closure of the orbicularis oris muscle and the overlying vestibular mucosa with interrupted sutures of 5-0 Vicryl. Upon completion of this, the face and mouth were washed of all dried blood and heme.
The puncture wounds of the right alar were then scrubbed clean, but no benefits of any suturing. All of the wounds were then dressed with bacitracin ointment and a contoured dressing of the upper lip to relieve the pressure.
The volar surface of the right hand was scrubbed clean with
Betadine solution and topically dressed.
All of the procedure went entirely well, without any problems or difficulties.

Postoperatively: the patient was to be continued on a course of antibiotics, analgesics for pain, no aspirin or aspirin products, Peridex mouthwash, mechanical soft diet, no straws, and no lifting, bending, stooping, or straining. All of the areas are to be kept lightly coated with bacitracin ointment, no crusting or scabbing. Call if there are any problems. Signs of infection were discussed. No hot drinks and the benefits of ice cream and a course of antibiotics were discussed.Call for an office appointment to be seen within the week.

The patient's mother and father were fully aware of the procedure, the risks, the options,
and the need for followup care. After an adequate period of time in observation, the patient was able to be
discharged in the accompaniment of her mother and father for followup in our office.

CC: John J. Vaccaro, M.D.

Electronically signed by John J Vaccaro, MD at 1/1/2018 14:54

Revision History ⌄⌄

Media

Electronic signature on 12/29/2017 23:36 : father signed

Activity Date

Activity Date

Dec 30, 2017

Routing History ⌄⌄

EXHIBIT J

JOHN J. VACCARO, M.D., P.A., F.A.C.S.

Member
American Society for Aesthetic Plastic Surgery, Inc.

Diplomate American Board of Plastic Surgery
Fellow of the American College of Surgeons

Member
AMERICAN SOCIETY OF PLASTIC SURGEONS

ASSIGNMENT OF BENEFITS
&
LTD. POWER OF ATTORNEY

I irrevocably assign to you, my medical provider, all of my rights and benefits under my insurance contract and/or any employee welfare benefit plan for payment for services rendered to me, including but not limited to all of my rights under "ERISA" applicable to the medical services at issue. I authorize you to file insurance claims on my behalf for services rendered to me and this specifically includes filing arbitration/litigation in your name on my behalf against the PIP carrier/health care carrier. I irrevocably authorize you to retain an attorney of your choice on my behalf for collection of your bills. I direct that all reimbursable medical payments go directly to you, my medical provider. I authorize and consent to your acting on my behalf in this regard and in regard to my general health insurance coverage and I specifically authorize you to pursue any administrative appeals conducted pursuant to "ERISA".

In the event the insurance carrier responsible for making medical payments in this matter does not accept my assignment, or my assignment is challenged or deemed invalid, I execute this **limited/special power of attorney** and appoint and authorize your collection attorney as my agent and attorney to collect payment for your medical services directly against the carrier in this case, in my name, including filing arbitration demand or lawsuit. I specifically authorize that attorney to file directly against that carrier in my name or in your name as a medical provider rendering services to me and designate your collection attorney as my attorney in fact. I further grant limited power of attorney to you as my medical provider to receive and collect directly from the insurance carrier money due you for services rendered to me in this matter, and hereby instruct the insurance carrier to pay you directly any monies due you for medical services you rendered me. **I authorize you and or your attorney to receive from my insurer, immediately upon verbal request, all information regarding last payment made by said insurer on my claim, including date of payment and balance of benefits remaining.**

I authorize you and or your attorney to obtain medical information regarding my physical condition from any other health care provider, including hospitals, diagnostic centers, etc., and I specifically authorize such health care provider(s) to release all such information to you about me, including medical reports, X-ray reports, and any other report or information regarding my physical condition.

Dated: 1/8/18

[redacted]
Patient's Signature

EXHIBIT K

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

United HealthCare
PO Box 29130
Hot Springs AR 71903

CARRIER

PICA ☐ PICA ☐

1. MEDICARE ☐ (Medicare#)	MEDICAID ☐ (Medicaid#)	TRICARE ☐ (ID#/DoD#)	CHAMPVA ☐ (Member ID#)	GROUP HEALTH PLAN ☐ (ID#)	FECA BLK LUNG ☐ (ID#)	OTHER ☒ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1259651101

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
[redacted] Sophie	[redacted] M ☐ F ☒	Bo[redacted]
5. PATIENT'S ADDRESS (No., Street): [redacted]	6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☒ Other ☐	7. INSURED'S ADDRESS (No., Street): 24[redacted]
CITY: [redacted] STATE: NJ	8. RESERVED FOR NUCC USE	CITY: [redacted] STATE: NJ
ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]		ZIP CODE: [redacted] TELEPHONE (Include Area Code): ([redacted]

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER: GJ1037
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☒	a. INSURED'S DATE OF BIRTH MM DD YY [redacted] / SEX M ☐ F ☒
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES ● NO ☒ PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES ☐ NO ☒	c. INSURANCE PLAN NAME OR PROGRAM NAME: United HealthCare
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED Signature On File DATE 06 11 19

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED Signature On File

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES ☐ NO ☒ $ CHARGES 0 00
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0		22. RESUBMISSION CODE ORIGINAL REF. NO.
A. S01 511A B. C. D. E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 12 29 17 12 29 17	23		13152		A	26006 00	1		NPI	1861463267
2 12 29 17 12 29 17	23		99284	25	A	861 00	1		NPI	1861463267
3									NPI	
4									NPI	
5									NPI	
6									NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
22 2550670 ☒	2753	YES ☐ NO ☒	$ 26867 00	$ 5115 00	21752 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (732 914 2100
John J Vaccaro M D 06 11 19 SIGNED DATE	Hackensack University Medical Center 30 Prospect Avenue Hackensack NJ 07601 1914 a. 1609862036 b.	John J Vaccaro M D P A 202 Route 37 West Suite 1 Toms River NJ 08755 8055 a. 1730372665 b.

EXHIBIT L

Oxford Health Plans NY Inc
UnitedHealthcare - Oxford
4 Research Drive
Shelton CT 06484
Phone: 1-800-666-1353

STD - PRA

UnitedHealthcare Oxford

PROVIDER REMITTANCE ADVICE

CHECK DATE: 02/05/18
TIN: 222550670
VENDOR NAME: JOHN J VACCARO MD PA
CHECK NUMBER: 15938217
CHECK AMOUNT: $5,115.00
VENDOR ID: DO4937-P933245

JOHN J VACCARO MD PA
PO BOX 249
HASBROUCK HEIGHTS NJ 07604

PATIENT: SOPHIE B[redacted]

MEMBER ID: 12596511*03 PATIENT ACCT NUM: 2753 CLAIM NUMBER: 8011E29267
PROVIDER ID: P933245 PROVIDER NAME: VACCARO, JOHN

DATE(S) OF SERVICE	DESCRIPTION OF SERVICE	QTY	BILLED AMT	MAXIMUM AMOUNT	DEDUCTIBLE AMT	COPAY/COINS AMT	COB AMT	WITHHOLD AMT	PAYMENT AMT	PATIENT RESP AMT	ADJ CODE
12/29/17	REPAIR OF WOUND OR LESION (13152)	1	$26,006.00	$4,254.00			$0.00	$0.00	$4,254.00	$0.00	A31P
12/29/17	ER DEPART VISIT HIGH/URGE SEVER (99284-25)	1	$861.00	$861.00			$0.00	$0.00	$861.00	$0.00	
CLAIM 8011E29267 SUBTOTAL			$26,867.00	$5,115.00			$0.00	$0.00	$5,115.00	$0.00	
								TOTAL PAYABLE TO PROVIDER	$5,115.00		

Adjustment Code Description

A31P The maximum amount allowed for this primary procedure has not been reduced based on the multiple procedures policy.

For the above claims please visit www.oxhp.com

EXHIBIT M

Patient Information

Patient Name	MRN	Sex	DOB
Hamid R Zarei	103275563	Male	[redacted]

Operative Report signed by John J Vaccaro, MD at 2/2/2018 14:07

Author: John J Vaccaro, MD	Service: (none)	Author Type: Physician
Filed: 2/2/2018 14:07	Date of Service: 1/31/2018 0:00	Status: Signed
Editor: John J Vaccaro, MD (Physician)		Trans ID: H1583792

Dictation Time:	Trans Time:	Trans Doc Type:	Trans Status: Available
2/1/2018 17:00	2/2/2018 5:32	Operative Report	

SURGEON: John J. Vaccaro, M.D.
CO-SURGEON: N/A
ASSISTANT: N/A
ANESTHESIOLOGIST:
DATE: 01/31/2018.

OPERATION: Right Hand/Index Finger: Exploration and debridement of complex stellate crush traction injury of the dorsum of the right index finger, extending through the radial side (extensor zones 1 and 2). There was reduction of the bony fragment with stabilization. There was repair of the shredded extensor tendon. There was repair of the radial digital nerve. There was repair of the dermis and its integument (9 cm). There was insertion of K-wire fixation. There was protective splinting.

ANESTHESIA:
1% lidocaine plain supplemented by 0.5% Marcaine plain
4X loupe magnification utilized
K-wire insertion
intravenous antibiotics administered.
TOURNIQUET TIME: 1-1/2 hours plus 1/2 hour

PRE-OP DX: Complex trauma of the right index finger secondary to a crush traction injury.

POST-OP DX: Right Hand/Index Finger: Complex stellate oblique angular avulsion and disruption of the dorsum of the right index finger, extending through the radial surface secondary to a crush traction injury (extensor zones 1 and 2). There was disruption of the dermis and its integument with devitalization (7 cm). There was disruption of the radial digital nerve, artery, and vein. There was shredding of the extensor tendon and displaced bony fragments.

HISTORY: This patient is a 58-year-old ambidextrous, although more right-hand dominant, male, who presents with a crush traction injury to the right index finger secondary to a heavy metal desk that he was moving at work that fell on his right index finger.

Upon evaluation by the primary physician, a plastic surgical consultation was requested.
The patient agreed to the consultation as well as the treatment for the involved injury. He was fully
aware of the options. He was fully aware over multiple times of the extent and the severity of the injury, including the possibilities of sympathetic reflex dystrophy, need for occupational and physical therapy, and extension lag was explained to him as well as possibility of further surgery, including fusion of the DIP joint.

PAST MEDICAL HISTORY: There is no history of known medical allergies. He has a history of hypertension. His medication is Aprovel, and he was updated on his tetanus immunizations today.

PHYSICAL EXAMINATION: General: A well-developed, well-nourished male, alert, oriented, acting appropriately for the trauma involved and appearing neurologically intact, except for the radial digital nerve of his index finger. Head, Ears, Eyes, Nose, Neck, and Oral Cavity: Grossly within normal limits. Chest, Heart, Lungs, and Abdomen: Grossly within normal limits. Extremities: Examination of the right index finger reveals a jagged stellate angular avulsion of the dorsum of the soft tissue, extending down to the underlying bone,
with exposed fragmented extensor tendon and extending through the radial side. The radial digital nerve sensation distally to the zone of injury was absent as well as the neurovascular
bundles, as noted intraoperatively. The patient was unable to extend his DIP joint. Flexion was intact. There was good capillary refill of the distal pulp.
After evaluating the patient, it was discussed with him at length the nature of the injury, that there would be a residual effect from the involved injury, the quality of which would have to be evaluated with time; the possibilities of bleeding, infection, hematoma, possibilities of further surgeries in the future, the strong possibilities of extensor lag, the possibilities of fusion, and the need for occupational and physical therapy, as well as sympathetic reflex dystrophy. We answered all of the patient's questions concerning the surgical procedure. The consent was a fully informed consent. He insisted we proceed.
The procedure took place as follows.

DESCRIPTION OF PROCEDURE: Intravenous was started. Intravenous antibiotics were administered and completed. The patient was brought into the operating room and placed on the operating room table in the supine position, with the injured hand extended on the hand table. Vital signs were noted and monitored to be stable. The hand was reexamined. A time-out was called, and the operative site as well as the patient identified and all agreed upon.
The hand was washed with soap and water and copiously irrigated with Betadine solution, followed by copious amounts of saline solution. The hand, wrist, and forearm were circumferentially cleaned, prepped and draped in the usual fashion, and isolated in a sterile towel field. There was induction of block

anesthesia utilizing 1% lidocaine plain, supplemented by 0.5% Marcaine plain, both without epinephrine. Allowing a 10-minute period of time to elapse for the complete anesthetic effect, the finger was exsanguinated and a tourniquet was placed at the base of the finger.
Upon completion of this, the wound was pulse irrigated and explored. There were no foreign body
fragments found, but there was shredded extensor tendon. There was an area of a bony avulsion fragment as well as the radial digital nerve disrupted, including the artery and the vein. There was devitalization of the dermis and integumental tissue on the dorsal aspect as well.
Upon completion of this, then, after exploration of the wound, my attention then turned to utilizing a K-wire to stabilize the distal phalanx and middle phalanx. Once this was completed, there was lengthening of the wound in both radial and ulnar directions performed with a #15 scalpel blade, followed by the micro iris scissors. The flaps were held back. Hemostasis was obtained with the cautery, and the
wound was again irrigated with saline solution.
My attention turned to the fragments of bone, which were reduced and placed in the areas of defect and sutured in place; my attention then turned to the fragmented shredded
extensor tendon. The extensor tendon was repaired with interrupted mattress sutures of 4-0 nylon. The wound was again irrigated with saline solution.
My attention now turned to the radial digital nerve, artery, and vein. The nerve was repaired with interrupted sutures of 7-0 nylon at 6 and 12 o'clock.
Upon completion of this, the wound was again irrigated, and the flaps that were raised were released and repaired with interrupted and running sutures of 5-0 nylon. The hand was elevated. The tourniquet was released, and pressure was maintained over the operative site for 10 minutes. A dressing of bacitracin ointment and Xeroform gauze was placed, incorporating a protective splint to the affected finger, hand, and forearm. At that point, the procedure was terminated. The patient tolerated the procedure well, without any problems or difficulties.

Postoperatively, the patient was to be given analgesics for pain, no aspirin or aspirin products. He was to be continued on a course of antibiotics.
He was to keep his hand elevated. Keep the dressing dry, clean, and intact.
Signs of infection were discussed. He is to avoid caffeine. Signs of infection discussed.
Call if there are any problems. Call for followup within the week.
The patient was fully aware of the procedure, the risks, the options, the need for followup care.
After an adequate period of time and observation, the patient was able to be discharged in the accompaniment of an adult for followup in our office.

CC: John J. Vaccaro, M.D.

Electronically signed by John J Vaccaro, MD at 2/2/2018 14:07

Revision History ⌄⌄

Media

EXHIBIT N

JOHN J. VACCARO, M.D., P.A., F.A.C.S.

Diplomate American Board of Plastic Surgery
Fellow of the American College of Surgeons

Member
American Society for Aesthetic Plastic Surgery, Inc.

Member
AMERICAN SOCIETY OF PLASTIC SURGEONS

ASSIGNMENT OF BENEFITS
&
LTD. POWER OF ATTORNEY

I irrevocably assign to you, my medical provider, all of my rights and benefits under my insurance contract and/or any employee welfare benefit plan for payment for services rendered to me, including but not limited to all of my rights under "ERISA" applicable to the medical services at issue. I authorize you to file insurance claims on my behalf for services rendered to me and this specifically includes filing arbitration/litigation in your name on my behalf against the PIP carrier/health care carrier. I irrevocably authorize you to retain an attorney of your choice on my behalf for collection of your bills. I direct that all reimbursable medical payments go directly to you, my medical provider. I authorize and consent to your acting on my behalf in this regard and in regard to my general health insurance coverage and I specifically authorize you to pursue any administrative appeals conducted pursuant to "ERISA".

In the event the insurance carrier responsible for making medical payments in this matter does not accept my assignment, or my assignment is challenged or deemed invalid, I execute this **limited/special power of attorney** and appoint and authorize your collection attorney as my agent and attorney to collect payment for your medical services directly against the carrier in this case, in my name, including filing arbitration demand or lawsuit. I specifically authorize that attorney to file directly against that carrier in my name or in your name as a medical provider rendering services to me and designate your collection attorney as my attorney in fact. I further grant limited power of attorney to you as my medical provider to receive and collect directly from the insurance carrier money due you for services rendered to me in this matter, and hereby instruct the insurance carrier to pay you directly any monies due you for medical services you rendered me. **I authorize you and or your attorney to receive from my insurer, immediately upon verbal request, all information regarding last payment made by said insurer on my claim, including date of payment and balance of benefits remaining.**

I authorize you and or your attorney to obtain medical information regarding my physical condition from any other health care provider, including hospitals, diagnostic centers, etc., and I specifically authorize such health care provider(s) to release all such information to you about me, including medical reports, X-ray reports, and any other report or information regarding my physical condition.

Dated: 02/06/18

Patient's Signature

EXHIBIT O

Oxford Health
P O Box 29130
Hot Springs AR 71903

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA | PICA

1. MEDICARE [ ] (Medicare#) MEDICAID [ ] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [X] (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1324732701
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Z[redacted] Hamid	3. PATIENT'S BIRTH DATE MM DD YY: [redacted] SEX M [X] F [ ]	4. INSURED'S NAME (Last Name, First Name, Middle Initial): Z[redacted] Hamid
5. PATIENT'S ADDRESS (No., Street): [redacted]	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street): [redacted]
CITY: [redacted] STATE: NJ	8. RESERVED FOR NUCC USE	CITY: [redacted] STATE: NJ
ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]		ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): Z[redacted] Hamid	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER: EG5312
a. OTHER INSURED'S POLICY OR GROUP NUMBER: W2A08119	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]	a. INSURED'S DATE OF BIRTH MM DD YY: [redacted] SEX M [X] F [ ]
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES [ ] NO [X]	c. INSURANCE PLAN NAME OR PROGRAM NAME: Oxford Health
d. INSURANCE PLAN NAME OR PROGRAM NAME: CNA	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO [ ] If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED Signature On File DATE 06 11 19

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED Signature On File

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES 0 00
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. ~~S56 421A~~ B. ~~S64 490A~~ C. ~~S62 630B~~ D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01 31 18	01 31 18	23		26418		A	13748 01	1		NPI	1861463267
2	01 31 18	01 31 18	23		64831		B	8883 23	1		NPI	1861463267
3	01 31 18	01 31 18	23		26765		C	6974 40	1		NPI	1861463267
4	01 31 18	01 31 18	23		99285	25	A B C	920 00	1		NPI	1861463267
5	01 31 18	01 31 18	23		29125		A B C	419 00	1		NPI	1861463267
6											NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 22 2550670 [X]	26. PATIENT'S ACCOUNT NO.: 2760	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [X]	28. TOTAL CHARGE $ 30944 64	29. AMOUNT PAID $ 4434 44	30. Rsvd for NUCC Use: 26510 20

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) John J Vaccaro M D SIGNED 06 11 19 DATE	32. SERVICE FACILITY LOCATION INFORMATION Hackensack University Medical Center 30 Prospect Avenue Hackensack NJ 07601 1914 a. 1609862036 b.	33. BILLING PROVIDER INFO & PH # (732 914 2100) John J Vaccaro M D P A 202 Route 37 West Suite 1 Toms River NJ 08755 8055 a. 1730372665 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

EXHIBIT P

121OXOPPR0026001-07480-02

Oxford Health Insurance Inc
UnitedHealthcare - Oxford
4 Research Drive
Shelton CT 06484
Phone: 1-800-666-1353

STD - PRA

UnitedHealthcare Oxford

PROVIDER REMITTANCE ADVICE

CHECK DATE: 04/30/18
TIN: 222550670
VENDOR NAME: JOHN J VACCARO MD PA
CHECK NUMBER: 26837860
CHECK AMOUNT: $4,434.44
VENDOR ID: DO4937-P933245

JOHN J VACCARO MD PA
PO BOX 249
HASBROUCK HEIGHTS NJ 07604

PATIENT: HAMID Z[redacted]

MEMBER ID: 13247327*01 PATIENT ACCT NUM: 2760 CLAIM NUMBER: 8094E06068
PROVIDER ID: P933245 PROVIDER NAME: VACCARO, JOHN

DATE(S) OF SERVICE	DESCRIPTION OF SERVICE	QTY	BILLED AMT	MAXIMUM AMOUNT	DEDUCTIBLE AMT	COPAY/COINS AMT	COB AMT	WITHHOLD AMT	PAYMENT AMT	PATIENT RESP AMT	ADJ CODE
01/31/18	REPAIR FINGER TENDON (26418)	1	$0.00				$0.00	$0.00	$0.00	$0.00	T317
01/31/18	REPAIR OF DIGIT NERVE (64831)	1	$8,883.23	$2,728.95		$545.79	$0.00	$0.00	$2,183.16	$545.79	A88R
01/31/18	TREAT FINGER FRACTURE, EACH (26765)	1	$0.00				$0.00	$0.00	$0.00	$0.00	T317
01/31/18	EMERGENCY DEPT VISIT (99285-25)	1	$920.00	$650.13		$130.02	$0.00	$0.00	$520.11	$130.02	A88R
01/31/18	APPLY FOREARM SPLINT (29125)	1	$419.00				$0.00	$0.00	$0.00	$0.00	TCOD
01/31/18	REPAIR FINGER TENDON (26418-51)	1	$13,748.01	$1,163.21		$232.64	$0.00	$0.00	$930.57	$232.64	A88R
01/31/18	TREAT FINGER FRACTURE, EACH (26765-51)	1	$6,974.40	$1,000.75		$200.15	$0.00	$0.00	$800.60	$200.15	A88R
CLAIM 8094E06068 SUBTOTAL			$30,944.64	$5,543.04		$1,108.60	$0.00	$0.00	$4,434.44	$1,108.60	
								TOTAL PAYABLE TO PROVIDER	$4,434.44		

Adjustment Code Description

A88R You do not participate in our network. As a result, the claim has been paid at 350% of the rate established by the federal government for the Medicare program for the services provided. The member is only responsible for any copayment, coinsuran and deductible amounts shown on this Remittance Advice statement. Please DO NOT contact our member about any other amounts and DO NOT balance bill the member. Contact Provider Services if you have any questions concerning the processin of this claim at 800-666-1353.

T317 This adjustment code has been applied to indicate that multiple surgical procedures were performed during the same operating session. This claim has been reimbursed in accordance with Oxford's Multiple Surgery policy, which is based upon generally accepted insurance industry standards for reimbursement of multiple surgical procedures. Under this policy, the primary procedure is reimbursed at 100% of the fee schedule (minus any applicable member cost-share). All subsequent procedures a reimbursed at 50% of the fee schedule. The primary surgery has been determined using the Medicare methodology of relying c the Relative Value Units (RVU). Participating providers may not balance bill the member for this service.

TCOD This service is ineligible for reimbursement as a separate procedure under Oxford policy, which is based upon Medicare's Correct Coding initiative (CCI). According to CCI, this procedure may not be billed with the other procedure(s) performed and not eligible for separate reimbursement. Participating providers may not balance bill the member for this service.

For the above claims please visit www.oxhp.com